

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Dasatinib**

**Initial application**

Applications only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase
or	
<input type="checkbox"/>	The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL)
or	
<input type="checkbox"/>	The patient has a diagnosis of CML in chronic phase
and	
<input type="checkbox"/>	Patient has documented treatment failure* with imatinib
or	
<input type="checkbox"/>	Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib
or	
<input type="checkbox"/>	Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system

**Renewal**

Current approval Number (if known):.....

Applications only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Lack of treatment failure while on dasatinib*
and	
<input type="checkbox"/>	Dasatinib treatment remains appropriate and the patient is benefiting from treatment

Note: \*treatment failure for CML as defined by Leukaemia Net Guidelines.

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)